Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR HEALTH CARE SYSTEM
2OO1 BRYAN STREET BRYAN TOWERS
DALLAS TX 75201

Respondent Name

TRAVELERS INDEMNITY COMPANY

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-11-2051-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guideline, Rule 134.404 states that reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount. After reviewing the account we have concluded that reimbursement received was inaccurate, Based on DRG 460, 'Inpatient Pricer 2010.A PSF 04/10, Discharges 10/2009-03/2010' allows $25,031.54 multiplied at 108% would be $27,034.06. Plus total cost of implants $16,921.67 in addition to 10 percent per bill item adds on of $1,692.16 would be $18,613.83. Reimbursement should be $45,647.89. Payment received was on $35,057.97 & thus, according to these calculations: there is a pending payment in the amount of $10,589.92."

Amount in Dispute: $10,589.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier contends the Provider is not entitled to additional reimbursement. Not only did the Carrier properly reimburse the Provider based on the documentation submitted with the billing, the Provider failed to timely exhaust its administrative remedies or invoke the jurisdiction of Division for Medical Fee Dispute Resolution."

Response Submitted by: Travelers, David Klosterboer & Associates, 1501 S. Mopac Expressway, Suite A-320, Austin, Texas 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2, 2010 through February 5, 2010	Inpatient Hospital Surgical Services	$10,589.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation. Texas Labor Code §413.011 (a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.404, titled

Hospital Facility Fee Guideline – Inpatient, effective for medical services provided in an inpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital inpatient services.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 19, 2010
   - DPAY –W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICED IN ACCORDANCE WITH THE DRG RATE.
   - INCG –W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICING INCLUDED IN THE DRG RATE.

   Explanation of benefits dated January 31, 2011
   - Z036 –193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY. APPEALS WILL BE NOT BE CONSIDERED AFTER THE FIRST DAY OF THE 11TH MONTH.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states in pertinent part that a request for medical fee dispute resolution shall be filed no later than one year after the date(s) of service in dispute or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. The dates of service in dispute are February 2, 2010 through February 5, 2010. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on February 24, 2011.
2. The Division finds no documentation support that the dispute was filed timely. Therefore, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the division finds that the requestor has established that no reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 9, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.